Sep. 14. 2012 2:48PM BROOKHAVEN MANOR No. 9298 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/29/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED C 445174 B. WING NAME OF PROVIDER OR SUPPLIER 08/30/2012 STREET ADDRESS, CITY, STATE, ZIP CODE BROOKHAVEN MANOR 2035 STONEBROOK PLACE KINGSPORT, TN 37660 SUMMARY STATEMENT OF DEFICIENCIES (GACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY F 164 (483.10(e), 483.76(l)(4) PERSONAL F 164 PRIVACY/CONFIDENTIALITY OF RECORDS Corrective action(s) accomplished for those residents found to have been affected: Resident #2 on 08/20/12 at 8:50 am upon observation The resident has the right to personal privacy and privacy curtain was then pulled around resident and confidentiality of his or her personal and clinical the door was closed for completion of the skin check records. How other residents having the potential to be affected were identified and correction action(s) accomplished: Personal privacy includes accommodations, All residents have same potential to be affected. medical treatment, written and telephone On 08/20/12 on 9:30 am and throughout the day DON communications, personal care, visits, and made rounds on all units and observed privacy curtains meetings of family and resident groups, but this being pulled and doors shut during resident care does not require the facility to provide a private and treatments. No dignity issues were observed. room for each resident. Measures or systematic changes put into place to ensure the deficient practice does not recur-Except as provided in paragraph (e)(3) of this Dignity/Privacy training provided to the treatment section, the resident may approve or refuse the nurse on 08/21/12 at 11a per the DON. release of personal and clinical records to any 100% of all staff in-serviced on Quality of Life individual outside the facility. dignity beginning on 08/21/12 per the DON. Training to be completed by 09/30/12. The resident's right to refuse release of personal In-service will be added to the new employee and clinical records does not apply when the orientation packet. resident is transferred to another health care Quality Assurance program put into place to monitor Institution; or record release is required by law. corrective actions and ensure the deficient practice will The facility must keep confidential all information DON or ADON will conduct observations or resident contained in the resident's records, regardless of care/tx 5 residents per week x 8 weeks to assure that the form or storage methods, except when each resident is cared for in a manner that promotes release is required by transfer to another dignity and respect, beginning on 08/21/12. Monthly healthcare institution; law; third party payment findings will be submitted to the Quality Assurance Committee who will determine used for future focus. contract; or the resident. This REQUIREMENT is not met as evidenced bv: Based on medical record review, observation and interview, the facility failed to ensure privacy during treatment for one (#2) of eight residents

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

alministrator 9/14/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days days following the date of survey whether or not a plen of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/29/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLEYED B. WING G 445174 NAME OF PROVIDER OR SUPPLIER 08/30/2012 STREET ADDRESS, CITY, STATE, ZIP GODE BROOKHAVEN MANOR 2035 STONEBROOK PLACE KINGSPORT, TN 37660 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) (D PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X5) COMPLETION TAG DATE DEFICIENCY) F 164 Continued From page 1 F 164 The findings included: Resident #2 was admitted to the facility on August 14, 2012 with diagnoses including Anxiety, Severe Diverticulosis, Gastrostomy Tube (G-tube for feeding), Hypertension, Benign Prostatic Hypertrophy, Fractured Femur with Open-Reduction Internal Fixation, Atrial Fibrillation and Dysphagia. Medical record review of an initial nursing assessment dated August 14, 2012 revealed the resident was alert; had short and long-term memory Impairment and severely impaired decision-making skills; had skin tears to the right elbow and wrist, a surgical incision on the right hlp, a scab on the left great toe and bruising. Observation of the resident in the resident's room for a skin check with Licensed Practical Nurse (LPN) #1/Treatment Nurse and Interview on August 20, 2012 at 8:40 a.m. revealed LPN #1 did not close the door to the resident's room but did pull the privacy curtain to the door to provide privacy from staff, other residents or visitors in the hallway. Observation revealed the LPN did not fully pull the privacy curtain around the resident. Observation revealed the alert and oriented roommate was in a wheelchair in the room; moving back and forth in full view of resident #2; and stated "He (resident #2) gets more attention than I do." Observation revealed Certified Nursing Assistant (CNA) #1 was assisting the roommate at the sink in view of resident #2. Observation revealed resident #2 was lying in bed with Oxygen (O2) at 2 liters per minute via nasel cannula. Observation revealed

Jevity 1.2 cal (calories) at sixty milliliters per hour

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/29/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 445174 NAME OF PROVIDER OR SUPPLIER 08/30/2012 STREET ADDRESS, CITY, STATE, ZIP CODE **BROOKHAVEN MANOR** 2035 STONEBROOK PLACE KINGSPORT, TN 37660 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX COMPLETION (XS) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING (NFORMATION) TAG TAG DATE DEFICIENCY) F 164 Continued From page 2 F 164 via the G-tube. Continued observation revealed an abdominal binder in place over the G-tube. Observation revealed both legs were wrapped in gauze. Interview with LPN #1 revealed the legs were "swollen and draining-seeping from both legs." Continued observation revealed a healing wound to the left great toe. Interview on August 20, 2012 at 8:48 a.m. in the resident's room with LPN #1/Treatment Nurse confirmed the privacy curtain was not pulled around the resident to provide privacy from the roommate during the skin check. Interview on August 20, 2012 at 8:50 a.m. with CNA #1 confirmed the door to the room was not closed during the observations. Continued interview confirmed if the privacy curtain was pulled completely around the bed of resident #2 "It leaves a gap at the door so anyone walking by could see" the resident. Continued interview confirmed the privacy curtain was not pulled and the roommate had full sight of the resident during the observations. C/O #29207, #29341 F 311 483.25(a)(2) TREATMENT/SERVICES TO F 311 IMPROVE/MAINTAIN ADLS SS≂D Corrective action(s) accomplished for those resident A resident is given the appropriate treatment and found to have been affected: services to maintain or improve his or her abilities Resident #5 was discharged from the facility on specified in paragraph (a)(1) of this section. How other residents having the potential to be affected were identified and corrective action(s) accomplished: This REQUIREMENT is not met as evidenced On 69/12/12 dietary manager reviewed 100% resident dietary orders for accuracy. Based on medical record review and interview. the facility failed to ensure sufficient and

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/29/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445174 NAME OF PROVIDER OR SUPPLIER 08/30/2012 STREET ADDRESS, CITY, STATE, ZIP CODE BROOKHAVEN MANOR 2036 STONEBROOK PLACE KINGSPORT, TN 37660 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX TAG TAG DATE **DEFICIENCY** F 311 Continued From page 3 F 311 F311 cont. appropriately trained staff were available to Physician diet orders were compared against maintain or improve eating abilities and failed to the dietary tray card and the monthly physician orders provide the appropriate food form for one resident On 09/12/12, ST reviewed all residents that are (#5) of eight residents reviewed. presently on ST case load for accuracy and to assure order is appropriate for resident to maintain or improve The findings included: cating ability. Measures or systematic changes put into place to Resident #5 was admitted to the facility on ensure the deficient practice does not resur: February 14, 2012 with diagnoses including All CNA's,, RN's, LPN's and therapy staff beginning? Fractured Tibla and Fibula with Open Reduction on 09/12/12 and ongoing have completed a chocking and Internal Fixation (February 1, 2012), (Obstructed Airway Clearance) competency. The Osteoporosis, Hypertension, Mental Retardation, competency check-off is being completed per the Paralysis Agitans, Anxiety Disorder, Depressive Risk Manager, DON or ADON. Will be completed Disorder, Parkinson's Disease and History of by 09/30/12. Colon Cancer. Daily review of all dietary orders per the DON, ADON or RN supervisor to assure all orders are appropriate Medical record review of the Minimum Data Set for resident to maintain or improve eating ability. (MDS) dated February 20, 2012 revealed the Quality Assurance program put into place to monitor resident had severely impaired decision-making corrective actions and ensure the deficient practice skills; was totally dependent on staff for all will not recur: activities of daily living (ADL) except for eating; Dietary manager will verify any diet change order with and had coughing or choking during meals or the DON or ADON to assure the diet order is appropriate for resident to maintain or improve eating when swallowing medications and required a mechanically aftered diet. Dietsty manager will audit 15 trays per week x 8weeks to essure diet served is accurate per MD orders. Medical record review of the physician's orders Findings will be submitted to Quality Assurance dated February 14, 2012 revealed the resident Committee on a monthly basis. The committee will received a regular diet. determine the need for future focus. Medical record review of a speech therapy screen dated February 15, 2012 revealed "...observed eating lunch with sitter at bedside...had no problem chewing...food, but...needed cues to eat

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slowly and to take one bit at a time. During this time...POA (Power of Attorney) was told that we do not allow private sitters at (facility)...pt (patient) was placed in restorative dining so...could be supervised at mealtime. Dietary was given a

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	Continued From pardietary communicates of mech (mechanic restorative dining" Medical record review "Rehab. Services Refebruary 15, 2012 re Nursing Program ifputs too much for mech-chopped-no in peelingInstructions you leaveput tray a backKeep a visual a day for 12 wks (we dated February 16, 2 CNAs (Certified Nursided Friday, February 16, 2 CNAs (Certified Nursided Fri	ge 4 ion form on diet (change) to local)-chopped meatPlaced in local)-chopped meatPlaced in local)-chopped meatPlaced in local ecommendations For." dated ecommendations For." dated evealed "Restorative local ecommendations for." dated evealed "mouthdiet is soft local ecommendations for local ecommendat		311	DEFICIENCY)	COPRIATE	DATE	
	(February 20, 2012), Medical record review February 20, 2012 re the resident to the ho health services.	w of a nurse's note dated vealed the family discharged me with plans for home						
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	the ST had been in "tendencies to chok ST "felt it was more home to puton ch confirmed the resid with eating but would spoon" and required Continued Interview reported the resider with (resident)." Co facility reduced restrive days a week-Mc ST "was afraidmig mechanical diet ove interview confirmed puree diet for the weedld not have restoral	v on August 21, 2012 at 12:10 ish Therapist (ST) confirmed formed the resident had se at home" on meat and the appropriate at the nursing opped meat." The ST ent required no assistance id place a "lot of meat on the is supervision with eating, revealed the restorative staff at "did really good if they sat intinued interview revealed the orative staffing from seven to or						
F 365 SS=D	C/O #29341 483.35(d)(3) FOOD INDIVIDUAL NEEDS	IN FORM TO MEET	F 36	35	F365		"a13013	
} { {	Each resident received food prepared in a food individual needs.	es and the facility provides im designed to meet			Corrective authon(s) accomplished for the found to have been affected: Resident #5 was discharged from the factor on 02/21/12. How other residents having the potential affected were identified and corrective	citity		
DM CHE has	Based on medical rathe facility falled to proone resident's (#5) neviewed.	r is not met as evidenced cord review and interview, ovide food in a form to meet eads of eight residents			accomplished: Dietary manager sudited 100% resident for securacy - compared physician order tray card. Completed on 09/12/12. On 09/12/12 Speech therapist reviewed receiving speech therapy savices to assert dietary order is accurate and appropriate to maintain or improve eating ability.	diet orders against all residents	AND	•

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/29/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO 0938-0391 (X1) PROVIDER/SUPPLIER/GLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A BUILDING B. WING 445174 NAME OF PROVIDER OR SUPPLIER 08/30/2012 STREET ADDRESS, CITY, STATE, ZIP CODE **BROOKHAVEN MANOR** 2035 STONEBROOK PLACE KINGSPORT, TN 37660 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL CX4) ID PROVIDER'S PLAN OF CORRECTION PREFIX ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X\$) COMPLETION DAT REGULATORY OR LSG IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) F 365 Continued From page 6 F 365 F365 cont Measures or systematic changes put into place to The findings included: ensure the deficient practice does not recur: In-service provided to 100% dietary staff per the Resident #5 was admitted to the facility on Dictary Manager and the Registered Dictician on February 14, 2012 with diagnoses including therapeutic diets and consistency of diets. To be Fractured Tible and Fibula with Open Reduction completed by 09/30/12 and Internal Fixation (February 1, 2012), lo-service will be added to the new employee Osteoporosis, Hypertension, Mental Retardation, orientation packet for distary employees. Paralysis Agitans, Anxiety Disorder, Depressive Quality Assurance program put into place to monitor Disorder, Parkinson's Disease and History of corrective actions and ensure the deficient practice Colon Cancer. will not recur: Beginning 09/12/12 dietary Manager will audit 15 Medical record review of the Minimum Data Set trays per week x 8 wks (MDS) dated February 20, 2012 revealed the to determine if the diet served is accurate for type and resident had severely impaired decision-making consistency per the physician order. Findings will skills; was totally dependent on staff for all be submitted monthly to the Quality Assurance activities of daily living (ADL) except for eating; Committee - who will determine the need for future and had coughing or choking during meals or focus. when swallowing medications and required a mechanically altered dlet. Medical record review of the physician's orders dated February 14, 2012 revealed the resident received a regular diet. Medical record review of a speech therapy screen dated February 15, 2012 revealed "...observed eating lunch with sitter at bedside...had no problem chewing...food, but...needed cues to eat slowly and to take one bit at a time. During this time...POA (Power of Attorney) was told that we do not allow private sitters at (facility)...pt (patient) was placed in restorative dining so...could be supervised at mealtime. Dietary was given a dietary communication form on diet (change) to soft mech (mechanical)-chopped meat...Placed in restorative dining..."

ዶ 11_{: ..} DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/29/2012 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED . STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING 445174 B. WING NAME OF PROVIDER OR SUPPLIER 08/30/2012 STREET ADDRESS, CITY, STATE, ZIP CODE **BROOKHAVEN MANOR** 2026 STONEBROOK PLACE KINGSPORT, TN 37660 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (X5) COMPLETION TAG TAG DATE DEFICIENCY) F 365 Continued From page 7 F 365 Medical record review of a document entitled "Rehab. Services Recommendations For;" dated February 15, 2012 revealed "...Restorative Nursing Program...eats too fast...will choke if...puts too much food in...mouth...diet is soft mech-chopped-no nuts, no food with peeling...Instructions...watch pt at mealtime...If you leave...put tray aside & (and) then give back...Keep a visual eye on...at all times...3 times a day for 12 wks (weeks)..." Medical record review of a speech therapy screen dated February 16, 2012 revealed "...reported by CNAs (Certified Nursing Assistants) & restorative aids that (resident) has not had any episodes of choking and...doing well on soft mech-chopped meats and supervision at meals..." Medical record review of a speech therapy screen dated Friday, February 17, 2012 revealed "...(Diet change) for the weekend...decided to change (resident's) meat to puree for the weekend because restorative does not work on the weekend...to be in dining room for all meals with supervision. Pt's meat was changed because that seems to be the food that ... crams into...mouth...On Monday I will change diet back to soft mech-restorative will be back on Monday (February 20, 2012)..." Medical record review of a nurse's note dated

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health services.

February 20, 2012 revealed the family discharged the resident to the home with plans for home

Telephone interview on August 21, 2012 at 12:10 p.m. with the Speech Therapist (ST) confirmed the ST had been informed the resident had

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 08/29/2012 FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 445174 NAME OF PROVIDER OR SUPPLIER 08/30/2012 STREET ADDRESS, CITY, STATE, ZIP CODE BROOKHAVEN MANOR 2035 STONEBROOK PLACE KINGSPORT, TN 37880 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG PREFIX (X5) COMPLETION TAG DATE DEFICIENCY) F 365 Continued From page 8 F 365 "tendencies to choke at home" on meat and the ST "felt it was more appropriate at the nursing home to put...on chopped meat." The ST confirmed the resident required no assistence with eating but would place a "lot of meat on the spoon" and required supervision with eating. Continued interview revealed the restorative staff reported the resident "did really good if they sat with (resident)." Continued interview revealed the facility reduced restorative staffing from seven to five days a week-Monday through Friday, and the ST "was efraid...might get choked..." if left on a mechanical diet over the weekend. Continued interview confirmed the resident was placed on a puree diet for the weekend because the facility did not have restorative staff available, and the ST planned to resume a soft mechanical diet on Monday, February 20, 2012. C/O #29341 F 441 483.65 INFECTION CONTROL, PREVENT F 441 SS≃D SPREAD, LINENS Corrective action(s) accomplished for those residents found to have been affected: The facility must establish and maintain an On 08/20/12 at 12:30p the DON assessed resident #3 Infection Control Program designed to provide a and resident #7. There was no change in baseline from safe, sanitary and comfortable environment and previous status as a result of dressing change procedure to help prevent the development and transmission DON observed isolation precaution procedure for thes of disease and infection. residents per the staff providing care - compliance noted. (a) Infection Control Program How other residents having the potential to be affected The facility must establish an infection Control were identified and corrective action(s). Program under which it accomplished: (1) Investigates, controls, and prevents infections Beginning on 08/20/12 at 1pm the DON conducted a in the facility: nursing assessment on all residents that required (2) Decides what procedures, such as isolation, treatment for a pressure or surgical wound. DON should be applied to an Individual resident; and assessed each resident for any sente signs of infection (3) Maintains a record of incidents and corrective or wound status changes - none were noted. This same actions related to infections. residents were assessed dally x 3 for any acute signs of infections or wound status changes by the DON.

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F 441	Continued From pag		F	441	F441 cont			
	(b) Preventing Spre	ad of Infection			No =====		Ì	l
	(1) When the infecti	OR Control Program	•		No symptoms were noted. Measures or systematic changes put			l
	deretwines that a te	Sident needs isolation to			cosure the deficient practice does n	into place to		۱
*	hievent the spread (of infection, the facility must	1		On 08/20/12 at 11a clean dressing o	ocrecur:	1	ĺ
	isolate the resident.				compelency was completed with th	e money verv nende]	l
	(a) The facility Must	prohibit employees with a			nurse per the DON.	o woming care	1	l
	from direct contract.	se or infected skin lesions		j	Beginning on 08/21/12 clean dressir	12 change	1	ı
]	direct contact will tra	vith residents or their food, if			competencies conducted with all Li	N and RN		ı
	(3) The facility much	memit me disease.		- 1	Staff per the Risk Manager, DON or	ADON. To,	. A	ı
	hands after each dir	require staff to wash their ect resident contact for which		- 1	be completed by 09/30/12.		<u> </u>	l
	hand washing is indi	Cated by contact for Which		- !	Change dressing change competency	will be		ĺ
}	professional practice	dated by accepted			added to the new employee orientati	on pack for		ĺ
	Production (Production	••		ĺ	all LPN's and RN's.		15	ĺ
	(c) Linens				Quality Assurance program put into monitor corrective autlons and ensur	place to		
ļ	Personnel must harv	die, store, process and		-	practice will not recur:	e the deficient	* * * * * * * * * * * * * * * * * * * *	
f	manishorr intells 20 S	s to prevent the spread of		- }	Beginning on 08/21/12 the DON or A	ADON wast's	√5.°°	ĺ.
į	infection.				observe wound care/or provided ner (ha muse	[ľ
ĺ		ſ		ı	I X week for 12 weeks to assure com	pliance with		
[- [clean dressing changes - compliance	with		
i	This DEAL UDEAL A	.		- 1	infection control measures to provide	a safe,	1 7 1674	
	py;	T is not met as evidenced		- 1	senitary and comfortable anvironmen	t and to	***	
					prevent the development and transmit disease and infection.	SSION of		
į	Teview observation of	ecord review, facility policy and interview, the facility		- 1	Findings to be reported monthly to th	e Omatini	. · · · · ·	
	falled to ensure anno	opriate infection control was		ı	Assurance Committee.	c Amilia		
i	implemented during	dressing changes and for		- 1		. [•	
•	prevention of possible	e cross contamination		ļ		_ }	4.4.85	
ļ	Infections for two (#3 reviewed,	and #7) of eight residents					* * * * * * * * * * * * * * * * * * *	
},	The findings Included	f:				1.50		
	Resident#3 was ada	nitted to the facility on July 3,		ļ		ļ]	
1	2012 With diagnoses	including Hypertension,		Į				:
- 17	Anemia, Cerebral Va	scular Accident (Stroke),				· /	20%	-
18	Obesity, Osteoarthriti	s and Severe Degenerative		-				
	_; = -:+++·***	AAACIA DERENDIANA		-	•	1	<u></u>	
What DIAD ONG	****	*					A 1	

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191A EMENT DE DECIMENALES		X1 BROWNERIOUS CONTROL			OMB NO. 0938-0391		
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTI NLOIN	PLE CONSTRUCTION	(3) DATE SURVEY. COMPLETED	
<u> </u>		445174	B. Wi	NG_		l	C
NAME OF F	PROVIDER OR SUPPLIER			T		08/3	0/2012
BROOK	HAVEN MANOR			2	REET ADORESS, CITY, STATE, ZIP CODE 035 STONEBROOK PLACE (INGSPORT, TN 37680		
(X4) ID PREFIX	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	'- '			
TAG	REGULATORY OR L	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IX.	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPROFICIENCY)	II D AR	(X6) COMPLETION DATE
F 441	Medical record revie report dated June 2	w of a hospital operative 3, 2012 revealed "history of	F	441			
	scored 9 of 15 on the Status (BIMS) with a decision-making skill assistance with active had almost constant and as needed pain pain as "10" the work	ew of the Minimum Data Set 2012 revealed the resident e Brief Interview for Mental noderate Impairment of its; required extensive to total rities of daily living (ADLs); pain; received scheduled medication; and rated the st pain imagined. Continued evealed the resident had a					
	Medical record review dated July 3, 2012 re incision on the right h	w of a nursing assessment evealed the resident had an hip with staples.					
	dated August 14, 20° (Discontinue) order fi (Right) hip (with) N/S Mupuricin (Mupirocin	or hip incisionCleanse (Normal Saline) apply -antibiotic) cint (cintment).					Design 1
	August 18, 2012 (Sai "This nurse was told Assistant) that res. (n Wound was draining a	v of a nurse's note dated turday) at 9:30 p.m. revealed by CNA (Certified Nursing esident's) previous surgical a large amountobserved a ng from top of previous					



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 08/29/2012 FORM APPROVED . STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 9. WING C 445174 NAME OF PROVIDER OR SUPPLIER 08/30/2012 STREET ADDRESS, CITY, STATE, ZIP CODE BROOKHAVEN MANOR 2036 STONEBROOK PLACE KINGSPORT, TN 37660 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (PACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX ID (X5) COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG F 441 Continued From page 11 F 441 incision. (Family) was in the room & demanded for res (resident) to be sent to hospital "to get something done." Continued review revealed the physician was notified and orders were received to transfer the resident to the hospital. Medical record review of the emergency room record dated August 18, 2012 revealed "...had right hip surgery approx (approximately) 1 month ago and now has "hole" in the inclsion area which is draining green fluid... affected area is painful...has redness...swelling...Severity of symptoms is moderate...History suggestive of: Post Op Wound Infection... Would suspect MRSA (Methicillin-Resistant Staphylococcus Aureus)...Doxycycline (antibiotic)...100 mg (milligrams)...2 times a day..." Medical record review of laboratory results of a culture of the right hip dated August 18, 2012 revealed "... Moderate growth of Staphylococcus Aureus..." Medical record review of a Nurse Practitioner (NP) progress note dated August 20, 2012 revealed "...(Right) hip surg (surgical) site...(with) plinhole opening upper third of incision, draining purulent (indicates presence of bacteria) material (with) foul odor. Appears to be a pocket of purulence in under side of incision. Able to

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express large amt (amount) of purulent drainage.

Review of the facility's policy for a clean dressing change revealed "...Procedure...Create clean field

Wound then cleaned (with) NS & ABD (Abdominal) pad applied...barrier adhesive

with paper towels or towlette drape..."

applied first...Wound infection..."

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Facility ID: TN8203

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/GLIA	Inch se		OWB MO	<u>), 0938-039</u>	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUIL	PLTTPLE CONSTRUCTION DING	(X3) DATE COMPI	SURVEY ETED	
		445174	B. WING		"	C	
NAME OF PE	AME OF PROVIDER OR SUPPLIER				OB/	30/2012	
BROOKH	BROOKHAVEN MANOR			STREET ADDRESS, CITY, STATE, ZIP 2035 STONEBROOK PLACE KINGSPORT, TN 37680			
(X4) ID PREFIX TAG	こういん ひとりじんけんごく	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S FLAN OF	ION SHOULD BE HE APPROPRIATE	(X6) COMPLETION DATE	
	revealed LPN #1 ap dressing dated Aug saturated with a lar, with a foul odor; and gloves, touched the positioning the resic the time of the obse was infected and co soiled dressing and removing the soiled observation reveale gloves and removed from the treatment of LPN #1 placed the s spray, Mupirocin oln gauze on the reside	terview with LPN #1 on August m. in the resident's room oplied gloves; removed the ust 19, 2012 which was ge amount of green drainage of then without removing the call light to get help with lent. Interview with LPN #1 at ervation confirmed the wound onfirmed the LPN removed the touched the call light without gloves. Continued of the LPN removed the soiled is supplies for wound care cart. Observation revealed supplies including Granulex attment, wound cleanser and nt's bed without a breside.	F 4	11			
ti n gibi d a Gu w	ine night hip wound; alonned clean gloves interest on the glov pintment to the wour he Mupirocin ointmet to the wour he Mupirocin ointmet gloves. Observable without using a evealed the LPN the gloves; donned clear andage to the wour livessing from the dig applied Granulex spray on the ising a barrier; and a wound. The LPN revashed the hands; a	removed the gloves and removed the gloves and red index finger; applied the not, then replaced the cap on ent without removing the rivation revealed LPN #1 of ontment on the over-bed in barrier. Observation en removed the soiled in gloves and applied a gauze and. The LPN removed a pht heel; cleansed the wound; ray to gauze; placed the moved the soiled gloves; and placed the Granulex he treatment cart and the					

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Event ID: FW6111

Facility ID: TN8203

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STATEMENT OF DEPICIENCIES (X1) PROVIDERISHBULBRICUM						OMB NO. 0938-0391		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:		(C2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
·		445174	B. WI	NG			C	
NAME OF PROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE	08/3	30/2012		
	HAVEN MANOR			20	SE STONEBROOK PLACE INGSPORT, TN 37660			
(X4) ID PREFIX TAG	: (EAUR DENCIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REPERENCED TO THE APPR DEPICIENCY)	IR D RE	COMPLETION DATE	
F 441	Mupirocin olntment LPN then placed the treatment cart aside Granulex. The LPI olntment from the u olntment in the treat Interview on August	in the uniform pocket. The can of Granulex spray in the eleven other cans of the removed the Mupirocin niform pocket and placed the ment cart.	F	441				
	the eleven cans of C treatment cart belon Continued Interview Granulex spray and to resident #3 (with a placed on the reside without a barrier; the on top of the treatmed drawer next to cans with wounds. Continuity Mupirocin cintment of pocket of LPN #1; in then placed back in	/Treatment Nurse confirmed 1						
·	Resident #7 was adr 2, 2012 with diagnos Ulcer, Depressive Di Dementia, Cerebrov Osteoporosis, Edem	mitted to the facility on August					100 mg	
	assessment dated A resident was admitte the right hip, the righ partial Amputation of	w of the initial nursing ugust 2, 2012 revealed the d with a Pressure Ulcer on t ankie and heel and with a if the left great toe. w of the MDS dated August						

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Facility ID: TN8203

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/29/2012. CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER. A BUILDING COMPLETED C B, WING 445174 NAME OF PROVIDER OR SUPPLIER 08/30/2012 STREET ADDRESS, CITY, STATE, ZIP CODE **BROOKHAVEN MANOR** 2035 STONEBROOK PLACE KINGSPORT, TN 37660 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID. PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 441 Continued From page 14 F 441 12, 2012 revealed the resident had short and long-term memory problems and severely impaired decision-making skills; had behavioral symptoms directed toward others (example: hitting, kicking, pushing, scratching, grabbing); was totally dependent on staff for all ADL; was assessed at risk for the development of Pressure Ulcers; and had two Stage 2, one Stage 3 and one Stage 4 Pressure Ulcers. Medical record review of a final "critical" laboratory report dated August 19, 2012 for a wound culture of the right hip (collected on August 13, 2012) revealed "...Moderate (3+) Escherichla coli (intestinal bacteria)...Many (4+) Proteus mirabilis (intestinal baoteria)...Many (4+) Staphylococcus aureus-Methicillin...Methicillin Resistant Stephylococcus aureus isolated...Moderate (3+) Enterococcus Faecalis (intestinal bacteria)..." Medical record review of a NP progress note dated August 21, 2012 revealed the NP had knowledge of the laboratory report dated August 19, 2012; spoke with the physician about the results and "...probable contamination and/or colonization of wound. Will continue to monitor for acute (changes) which signify infection. Cont. (Continue) current wound care measures." Observation on August 20, 2012 at 10:25 a.m. of LPN #1/Treatment Nurse providing wound care

revealed the resident was lying in bed with an air mattress in place. Observation revealed LPN #1 removed wound care supplies from the treatment cart including Granulex spray, Santyl ointment (use for debridement of wounds), Algicell pads (dressings used to absorb large amounts of

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLEA					OMB NO. 0938-0391			
AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	ILTIPLE CONSTRUCTION DING	(X3) DATE	SURVEY		
		445174	B. WIN	G		C		
NAME OF PROVIDER OR SUPPLIER BROOKHAVEN MANOR			98/30/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 2035 STONEBROOK PLACE KINGSPORT, TN 37660					
(X4) ID PREFIX TAG	I CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	V SHOULD AF	(XS) COMPLETION DATE		
	resident's bed withouthe bed. Continued performed wound continued performed wound content to be using Granulex, the contant on the over-bed tab. Observation revealed dressing from the rigiough) and a foul of the continuent placed the Continuent placed the Continuent placed the Santyl in the uniform the treatment cart; replaced the Santyl or barrier. Interview on August hallway with LPN #1 and #7 had infected Granulex, Algicell, Sesident #7 were placed on the over-barrier after being up Continued interview in the uniform pocked on the treatment care confirmed Granulex.	and placed the supplies on the put placing a clean barrier on a observation revealed LPN #1 are on the right ankle and left nulex spray. Observation #1 finished applying the aliner of Granulex was placed le without a barrier. Led LPN #1 removed the ght hip which revealed escharodor. Observation revealed wound care to the right hip t and after applying the Santyl on the resident's bed. Led the LPN then placed the pocket; left the room to open e-entered the room; and the over-bed table without a confirmed both residents #3 wounds and confirmed the leantyl and dressings for aced on the bed without a ced on the bed without a ced table without a clean sed during the treatments. Confirmed Santyl was placed at before being placed back to continued interview and Santyl were placed back without being cleaned and of the risk for	F 44	41				
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